# Transforming Medicaid

**House Bills 7223 & 7225 by Representative Denise Grimsley**

- Florida's Medicaid system in its current form is unsustainable. This year, funding for Medicaid is expected to consume 28.3% of the total state budget. The Federal Health Care Reform legislation recently signed into law by President Obama is expected to extend Medicaid to an additional 1 million Floridians, placing an even greater strain on our state budget.

- We are bringing more accountability to the system, cracking down on fraud, and improving patient care. This is a public program, using public dollars, and we should make sure that it is run efficiently and is held accountable to the recipients and taxpayers.

- Throughout the years, carve outs for special populations, regions, and vendors have complicated our Medicaid system and have made it one of the most complex system in the nation. The program consists of an intricate system of eligibility groups, financing, and service delivery models. The state operates both fee for service and managed care models and within the managed care model, the state operates 20 different "pilot" programs.

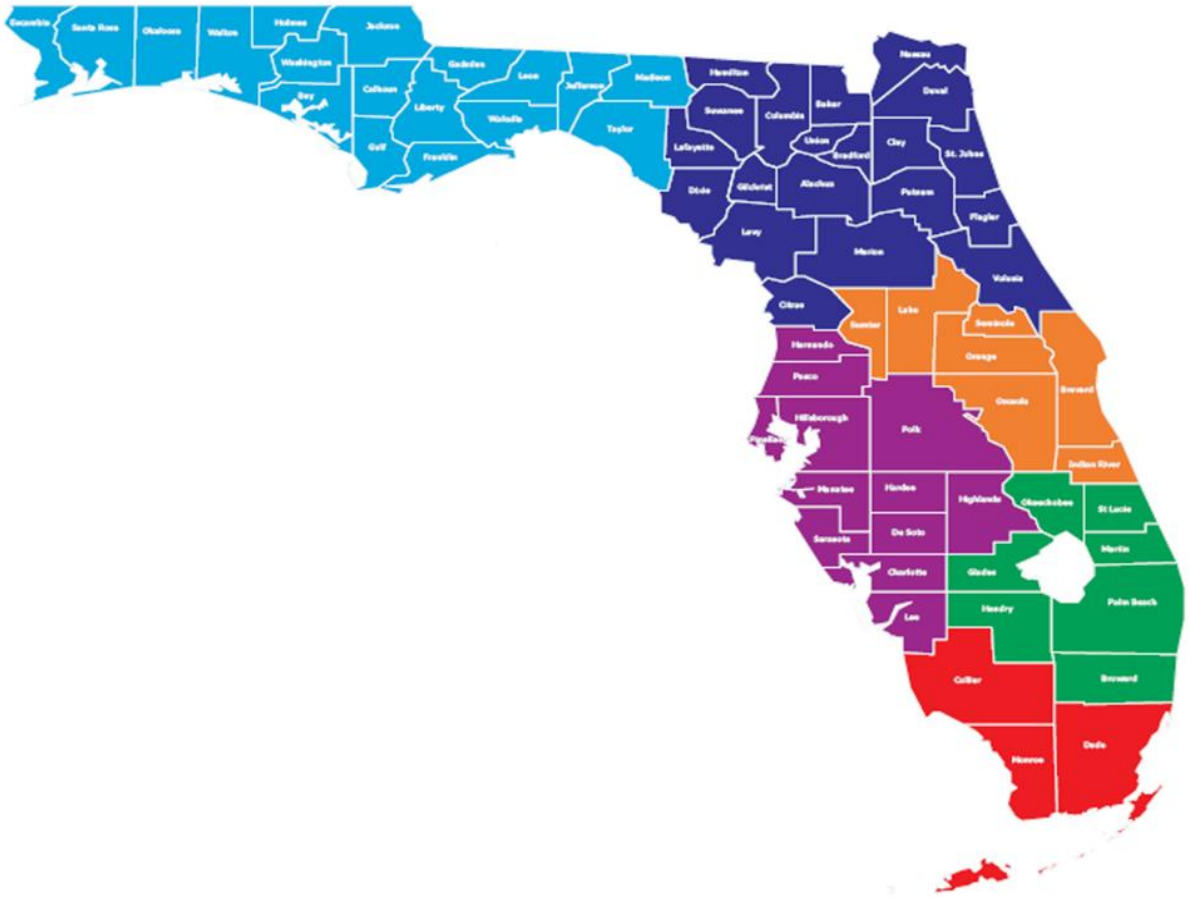
- The fee for service system model has proven to be considerably more expensive than managed care. According to the 2009 Social Services Estimating Conference, fee for service and managed fee for service served 58% of the Medicaid population while consuming 81% of the total Medicaid costs. Based on the same report, 42% of Medicaid participants utilizing the managed care model only accounted for 19% of total Medicaid costs.

- Moving to a statewide managed care model will increase accountability in the Medicaid system and improve care. The state will be divided into 6 geographic regions and each region will have the choice of several different plans including Provider Service Networks (PSN). Managed care plans will bid for 5 year state contracts that can offer customized benefit packages. Except for some PSNs, selected plans will be paid capitated risk-adjusted rates. This prevents cherry-picking by plans, as they will be paid more for sicker recipients.

**HB 7223**

## Expansion of Managed Care

HB 7223 sets forth a five-year implementation plan to move the state's Medicaid population to a managed care system. The state will be divided into 6 geographic regions and each region will have a minimum of 3-5 plans and a maximum of 7-10 depending on the region. Provider Service Networks are encouraged to participate and at least one PSN will be guaranteed per region so long as a responsive bid is submitted. If a PSN does not submit a responsive bid in a region, that slot must be held open for an additional 12 months, at which time the Agency for Health Care Administration (AHCA), will issue another ITN for interested PSNs.



- **Region 1** = Panhandle: Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington
- **Region 2** = North Central and North East Florida: Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns Suwannee, Union, and Volusia
- **Region 3** = West Central Florida: Charlotte, DeSoto, Hardee, Hernando, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, Sarasota
- **Region 4** = Central Florida: Brevard, Lake, Indian River, Orange, Osceola, Seminole, Sumter
- **Region 5** = Southeast Florida: Broward, Hendry, Martin, Glades, Okeechobee, Palm Beach, St. Lucie
- **Region 6** = South Florida: Collier, Miami-Dade, Monroe

Networks wishing to participate in the program will bid for 5 year contracts. The state will consider the following factors when choosing plans: accreditation; experience; adequacy of physician network; community partnerships; quality improvement programs; offers of additional benefits; participation history in the Medicaid program; evidence of written agreements , signed contracts, or substantial progress in establishing relationships with providers, with special weight given to plans that have contracts with a sufficient number of primary and specialty physicians and evidence that the compensation for such physicians is sufficient to retain them throughout the 5-year contract. Specific preferences are established for plans designated as medical homes or that have the greatest number of primary care providers that are recognized as patient-centered medical homes by the National Committee for Quality Assurance (NCQA), as well as plans that focus on minority recruitment. Plan contracts will have specific requirements and ensure quality of care to Medicaid participants. Additionally, this system will allow the state to measure outcomes in order to bring greater accountability to the system.

Except for certain PSNs, managed care plans will be paid at a per member, per month, risk-adjusted rate for their services. This allows the state to control costs and discourages cherry-picking by the plans, as they will receive a higher rate for sicker recipients. PSNs may still be fee-for-service for up to five years, but we establish specific requirements for shared savings and define guidelines for a reconciliation process that determines shared savings.

**Capitation (**general definition)**:** A payment method for health care services. The physician, hospital, or other health care provider is paid a contracted rate for each member assigned, referred to as "per-member-per-month" rate, regardless of the number or nature of services provided. The contractual rates are usually adjusted for age, gender, illness, and regional differences.

**Capitated Risk Adjusted Rate**: Pays the plan more for treating sicker patients

<u>Contract Requirements:</u>

- Plans must pay for non-contracted emergency services.
- Plans must meet access standards and maintain a public, online database with up-to-date information about contracted providers.
- Plans must submit encounter data, which will be analyzed by the agency on an on-going basis.
- Plans must establish specific performance standards that are raised over the term of the contract, as well as internal quality improvement systems that include incentives and disincentives for providers and enrollee satisfaction and disenrollment surveys.
- Plans must meet specific requirements to maintain program integrity and prevent fraud and abuse.
- Plans must maintain an internal grievance resolution process.
- Penalties are established for plans that reduce enrollment or withdraw prior to the end of a contract.
- Plans must comply with specified prompt payment requirements and accept electronic claims in

compliance with federal standards.

- Plans that are not designated as medical homes must develop a plan to assist, and provide incentives for, its primary care providers to become recognized as patient-centered medical homes by NCQA.

Recipients will receive a choice in plans, and may be provided choice counseling to assist in choosing a plan. Recipients who do not choose a plan within 30-days will be automatically assigned to a plan by the agency based on certain criteria. Enrollment periods are for 12 months; however, recipients can disenroll from plans under certain conditions. The bill provides specific requirements for handling recipients' grievances.

<u>Managed Medical Assistance Program:</u>

The Managed Medical Assistance (MMA) program, which consists of primary and acute medical assistance and related services, will be implemented beginning January 1, 2012, with full implementation statewide by October 1, 2013.

Plans selected for the MMA must cover all current mandatory and optional benefits now available for Medicaid recipients and may customize benefits packages for non-pregnant adults, vary cost-sharing and provide coverage for additional services subject to review by AHCA. The plans must provide enhanced benefits and enable recipients to earn and use credits in a flexible account for uncovered services. They must provide more credits for modifications or management of high cost behaviors such as smoking cessation and plans must maintain earned credits for up to 3 years.

*Accountability Measures:*

- The bill will establish accountability for managed care plans by measure spending for patients.
- Medical loss ratio thresholds are as follows:
    - If a plan spends less than 75% of Medicaid premium revenue on medical services and direct care management, the plan will lose its auto-enrollments (the plan will not be given any automatic recipient assignments) and must pay back up to 85%.
    - If a plan spends less than 85% of Medicaid premium revenue on medical services and direct care management, the plan must pay back the difference up to 85%.
    - If a plan spends more than 92% of Medicaid premium revenue on medical services and direct care management, AHCA will evaluate the plan to determine whether it is appropriately managing care.
    - If a plan spends more than 95% of Medicaid premium revenue on medical services and direct care management and is determined to be failing to adequately manage care, the plan will lose its auto-enrollments.

***Medical loss ratios look at the amount of costs spent on direct care to patients versus the amount spent on administration.***

- Plans are expected to maintain a ratio of 85% to 92%
- If a plan is spending less than 85% on direct care, then it is not providing sufficient care to its clients.
- If it is spending too much on direct care - more than 92%- the plan is not effectively managing client's care.
- If a plan is maintaining a loss ratio of more than 92%, the plan is likely not giving its participants the proper and necessary care which then requires more expensive and intense health care services to be implemented.

- Plans may limit the providers in their network based upon a number of factors; however, in the first contract period plans must offer a contract to Federally Qualified Health Centers (FQHC), Medical home certified primary care providers, statutory teaching hospitals, trauma centers, regional perinatal intensive care centers (RPICCs), and specialty children's hospitals.
- After 12 months, plans may exclude any of these providers from their network for failure to meet quality or performance measures; however, they must provide 30-days written notice to all recipients who have chosen that provider for care.
- The following providers must agree to participate in each qualified plan in its region: statutory teaching hospitals; trauma centers; RPICCs; specialty children's hospitals; and hospitals with both an active Medicaid provider agreement and a Certificate of Need (CON. Statutory teaching hospitals, trauma centers, RPICCs, and specialty children's hospitals must ensure medical staffing sufficient to fulfill their contractual obligations with the plans.
- Protections are established to ensure more equal bargaining power between providers and the plans. Although certain providers must participate in the plans if offered a contract, plans that have written agreements or signed contracts with providers prior to submitting a response to the ITN will be given special consideration during the selection process.
- Children's Medical Services is a qualified plan and will be exempt from the selection process applicable to other plans; however, it must meet all other plan requirements.
- Plans must measure quality and performance of providers based on transparent metrics.
- Plans are also subject to quality and performance measures and plans that are deficient in any such measures are excluded from auto-enrollments.
- Plans must have special provisions for improving pregnancy outcomes and infant health.
- Each plan must achieve an annual Early and Periodic Screening, Diagnosis, and Treatment Service screening rate of at least 80 percent of those recipients continuously enrolled for at least 8 months.
- Provider payments may be negotiated, but hospital rates must be a minimum of the Medicaid rate and no more than 150% of the Medicaid rate.

- AHCA must develop a methodology to ensure the availability of intergovernmental transfers (IGTs) to support providers that historically have served Medicaid recipients, such as safety net providers, trauma centers, statutory teaching hospitals, children's hospitals, and medical and osteopathic physicians employed by medical schools. The availability of these payments is subject to sufficient IGTs from allowable sources. The payments pass-thru plans and must be paid to providers within 15 business days after AHCA notifies the plans of provider-specific distributions.
- The agency may provide a conflict resolution process in limited circumstances.
- Medically needy will now be given 12 months continuous eligibility; and must be given a 120 day grace period before disenrollment for failure to pay their share of cost. Medically needy is an optional Medicaid benefit that our state provides.

## Long Term Care Managed Care Program

**Background**

- Florida's elderly population is growing. By 2030, Florida is estimated to have 7.8 million citizens age 65 or older - a 56.4% increase from the 3.4 million seniors today.
- 14.25% of Florida's Medicaid population is over 65, but Florida spends 19.7% of it Medicaid dollars on the elderly.
- This legislation creates a managed care program that that emphasizes home and community based care. The program rewards plans that keeps seniors out of nursing homes and builds on Florida's existing home and community based service network.
- Florida spends over $50,000 per year for an individual in a nursing home, but often can provide home and community based services for under $20,000 per year.
- Arizona has one of the oldest managed care programs for long-term care. Only 33% of Arizona's elderly Medicaid recipients are in nursing homes.

Floridians meeting specified eligibility requirements will be enrolled in long-term care managed care plans. Implementation will begin July 1, 2011 with full implementation by October 1, 2012. AHCA will manage the program, but may delegate certain duties to the Department of Elder Affairs such as: assisting with bid selection; determining clinical eligibility; assisting in monitoring plans; assisting families; and facilitating interactions between plans, providers, and others.

Eligible recipients must be aged 65+ or eligible for Medicaid by reason of a disability and determined by the Comprehensive Assessment Review and Evaluation for long-Term Care Services (CARES) Program to require nursing home care. Recipients enrolled in a long-term care waiver program at the time long-term care managed care is implemented in each region will be eligible to participate.

Two types of plans will be available for recipients: **comprehensive plans** that combine medical and long-term care services and **long-term care plans** that only provide long-term care services. Preference will be given to comprehensive plans so seniors can receive all their services from one plan.

For purposes of the Long-Term Care Managed Care Program, Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-Sponsored Organizations, and Medicare Advantage Special Needs Plans are qualified plans. This will ensure that dually eligible recipients can continue to receive services under their current Medicare plans.

In selecting long-term care managed care plans, AHCA must consider:

- Whether plans have specialized staff with expertise and experience in serving aged and disabled persons who require long-term care
- Whether plans have adequate and sufficient service providers throughout the region to meet specific service standards established by the agency for serving persons receiving home and community based care.
- Whether the plan proposes to establish a comprehensive long-term care plan. Plans that do are given preference.
- Whether the plan is designated as a medical home network or offers consumer-directed care services to enrollees. When all other factors are equal, such plans are given a preference.
- Evidence that the plan has written agreements or signed contracts, or has made substantial progress in establishing relationships with providers in the region. AHCA will give special weight to plans that can evidence signed contracts with providers.

- Plans may limit the providers in their network based on certain criteria; however, during the first contract period, they must offer a contract to any nursing home, hospice or aging network service providers in the region. After 12 months, the plan may exclude any of these providers for failure to meet quality or performance standards.

- Nursing homes and hospices must participate in all qualified plans selected by the agency in the region.

- Program of all-inclusive Care for the Elderly (PACE) plans are qualified but exempt from procurement.

- Each plan must comply with specific standards related to the number, type, and regional distribution of specified providers in the region.

- While plans and providers may negotiate mutually acceptable rates, plans must pay nursing homes an amount equal to the nursing home facility-specific payment rates set by AHCA and hospices an amount equal to the per diem rate set by AHCA. For recipients residing in a nursing facility and receiving hospice services, the plan must pay the hospice provider the per diem rate set by AHCA less the nursing facility component and shall pay the nursing facility the appropriate state rate.

- Seniors want to stay in their homes as long as possible. This bill focuses on keeping seniors in their homes. Home and community based care is both required and rewarded. Payment rates will be

adjusted to create incentives for keeping individuals out of nursing homes as long as possible. At least 3% up to 5% re-balancing of nursing home and home and community based care is expected each year.

- The Comprehensive Assessment and Review for Long-Term Care (CARES) staff will continue to evaluate whether an individual meets a nursing facility level of care and will initially assign the individual to a level of care appropriate for their needs.

- Medical loss ratio thresholds will be the same as for the managed medical assistance program.
    - Less than 75% = payback up to 85% and loss of auto-enrollments
    - Less than 85% = payback up to 85%
    - Greater than 92% = evaluation by AHCA to determine effectiveness of care management
    - Greater than 95% and determined to be failing to adequately managing care = loss of auto-enrollments

- When a recipient does not choose a plan, AHCA will auto-assign the recipient to a plan that best fits the needs of the recipient.

- Specific roles for traditional aging service providers are preserved.
    - Aging Resource Centers will be a community access point for seniors seeking services and will either offer choice counseling to enrollees through a contract with AHCA, or will work cooperatively with the choice counseling vendors.
    - Plans must include all nursing homes and hospices and these providers must agree to participate in a plan's network if offered a contract.
    - Nursing homes and hospices will receive a "pass through" payment for services from the plan.

- Since hospice is such a special service, the bill provides an additional choice for hospice patients. When a senior is referred for hospice services, the senior will have a 30-day period to change plans if a preferred hospice provider is only available through another plan.

## Developmental Disabilities Managed Long-Term Care Program

The legislation creates a managed care program for persons receiving services under the Medicaid waiver program and in Intermediate Care Facilities for the Developmentally Disabled. Managed care offers the greatest potential for enhanced care coordination, integration of medical care and support services, and more predictable spending.

Those eligible will be enrolled in long-term care managed care plans for persons with developmental disabilities. Implementation shall begin July 1, 2014 with full implementation by October 1, 2015. AHCA will be responsible but may delegate certain duties to the Agency for Persons with Disabilities (APD) such as: assist with bid selection, determine clinical eligibility, assist in monitoring performance, assist clients and families interactions with plans, and facilitate interactions between plans and providers and others.

The bill provider service networks to provide residential and home and community based services; other types of managed care organizations must provide comprehensive coverage that includes medical assistance. Through the procurement and contracting process, AHCA will have the ability to set strong performance standards and have greater capacity to hold the contractor accountable for meeting these standards.

Consistency in Eligibility

- All current recipients will be transferred in to the new managed care program.
- Residents of Sunland Center and Tacachale Center are exempt from mandatory enrollment.
- Managed care provides budget predictability and incentives for efficiencies as well as bringing greater consistency to the quality of care. This approach is necessary because:
    - Budget deficits continue in this program despite numerous efforts to contain costs.
    - Frequent and extensive litigation interferes with legislative efforts to manage the program.
    - Medical care for the developmentally disabled is not well coordinated; managing care through an integrated system creates the opportunity for savings to be reinvested in home and community based services.
    - Our ability to eventually be able to serve individuals on the waitlist depends on a stable program with predictable spending.

Diverse Benefit Options

- The bill protects against disruptions in services by requiring participating plans to offer the same services as those currently provided in the waiver program and the Intermediate Care Facilities for Developmentally Disabled program.

- Services include at a minimum twenty home and community based services as well as services in licensed residential facilities.

- Because plans are able to customize benefits packages or offer additional benefits, it is possible that recipients may receive more care options than they currently receive.

Ensuring Qualified Plans

- The new law establishes requirements to ensure competent and effective providers are selected to serve people with developmental disabilities.

- Plans will be required to have contracts with all residential providers in their region that serve persons with developmental disabilities to ensure that recipients will not have to relocate or otherwise experience a disruption in services.

- Plans are required to include providers with experience in serving individuals with developmental disabilities. Provider service networks must include owners of licensed residential providers with at least 10 years of experience in serving people with developmental disabilities. Children's Medical Services is authorized to be a qualified plan.

- Although recipients are moving into a managed care environment, the legislation protects the ability of consumers and their families to be involved in the design and oversight of the plans.

Plan Selection Tailored to Ensure Effective Services

In selecting plans, preference will be given to those plans that:

- Offer consumer directed care services, allowing recipients and their families an opportunity to manage individual budgets and control the selection of service providers.

- Have management staff with experience working with individuals with developmental disabilities.

- Have provider networks that demonstrate accessible services and sufficient numbers of providers to serve the need. This will ensure recipients have access to the services they require throughout the region.

Plans Accountable to Their Clients

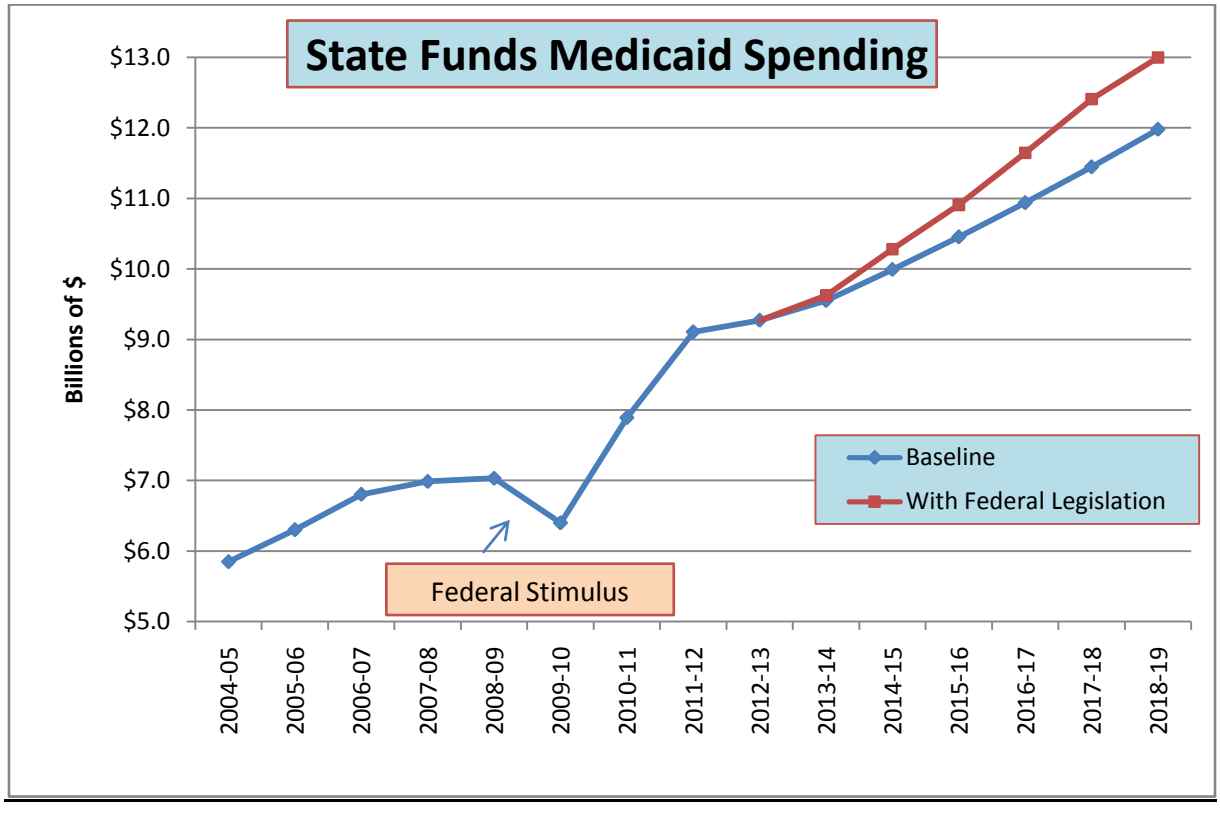
- All plans will be held accountable to spend at least 92 percent of their revenue on services and direct care management. Plans that fail to do so will be required to repay the difference.

Payment of Managed Care Plans

- Payment will be adjusted to reflect differences in conditions and needs of the clients; five specific levels of care are established. APD will perform the initial assessment and assignment of persons into levels of care

- Network providers and plans will negotiate mutually acceptable rates.

- Payments to intermediate care facilities for the developmental disabilities facilities and providers of intensive residential habilitation services will be determined by AHCA and plans will be required to pay these rates to providers.



**HB 7225**

This bill is contingent upon passage of HB 7223 and makes conforming changes to existing law in order to implement the statewide managed care Medicaid system.

## Immediate Changes to Managed Care Plans Statewide

We also implement new policies that build upon successes in the current reform areas that will apply to plans statewide.

- Beginning September 1, 2010, all qualified plans will begin the process of phasing in risk-adjusted rates over the next 3 years. This ensures a more sustainable program and discourages cherry-picking by the plans, as they will be paid more for care provided to sicker patients.
- We also require all qualified plans to develop enhanced benefits programs for Medicaid recipients. Enhanced benefits plans reward recipients for taking personal responsibility by engaging in certain healthy behaviors. We have seen a more enthusiastic level of participation in the pilot program counties in recent years and recipients statewide should enjoy the rewards associated with taking responsibility for their own health.
- Plans will be required to begin reporting medical loss ratios to the agency, which must be made public. This will provide valuable information to ensure that plans are providing adequately managed, patient-centered care. However, we will not attach any guidelines or associated consequences to plans until managed care is implemented statewide pursuant HB 7223.
- While many plans have begun to report encounter data to AHCA statewide, we establish a requirement for this data to ensure compliance by all plans. AHCA is required to review available encounter data to establish actuarially sound rates prior to using the encounter data to adjust rates for prepaid plans.
- We expand statewide the current option for Medicaid recipients in reform counties who may use their Medicaid premium to purchase employer-sponsored insurance; however, we build upon this option ( subject to federal approval) by allowing recipients to use their Medicaid dollars to pay for other insurance or products that may be available to them. This broadens the choice options for recipients while still bridging public and private coverage.

### Nursing Home Regulatory Relief

In order to enable nursing homes to be able to provide comprehensive services pursuant to the long-term care managed care program, it is essential that we ensure some regulatory relief to nursing facilities. To do so, we direct AHCA to establish a workgroup to develop a plan for licensure flexibility. Without this, nursing homes may face obstacles to providing other services to clients.

Additionally, nursing homes are provided CON relief in two ways:

- Current facility obligations related to utilization by Medicaid recipients are suspended, and
- Current CON moratorium on nursing home beds is extended until Medicaid managed care – medical assistance, long-term, and long-term for persons with developmental disabilities – is implemented

statewide or October 1, 2015, whichever is earlier.

iBudget

Area One of APD will participate in an ibudget (individual budget) demonstration project to test the effectiveness of the ibudget proposal serving people with developmental disabilities in the Medicaid program. This provides an opportunity to test other potential methods for managing recipient care prior to the implementation of long-term care managed care for persons with developmental disabilities.